

# Ethical Service Delivery to Culturally and Linguistically Diverse Populations: A Specific Focus on Gay, Lesbian, Bisexual, and Transgender Populations

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## **Abstract**

*Purpose: Shifting demographics amid a growing population have given rise to a culturally and linguistically diverse client base. Professionals' recognition and understanding of effective service delivery with individuals from culturally and linguistically diverse groups is improving. Cultural competence is emerging as a necessary skill set for practitioners to deliver clinically competent services with diverse communities including the gay, lesbian, bisexual, and transgender (GLBT) population.*

*Method: Current literature and Internet sources were used to gather demographic information analyze policy documents related to ethical service delivery and explore current trends and recommendations for appropriate service delivery with a specific focus on the GLBT population.*

*Results and Conclusions: The demographic makeup of the U.S. population is rapidly changing. Professionals, especially those outside urban areas, are only beginning to understand and adapt their clinical practices to adequately serve the GLBT population. Despite some resistance to change and political maneuvering, which could be construed to contradict ethical service delivery, professionals are realizing that ethical service delivery that embraces a recognition of their own culture and that of the individuals they serve results in greater functional outcomes.*

## **Changing Demographics**

It is an appropriate time to reassess our obligation to ethical service delivery to culturally and linguistically diverse populations within our profession. The population in the United States is growing, becoming more diverse and aging rapidly. Adequate service delivery in our profession to this dynamic population requires enhanced self-education about culture and our ethical responsibility to provide service delivery that incorporates an understanding of the cultural and linguistic background of the individuals we serve.

The demographics of our nation are changing rapidly. The current estimated population is 305 million (U.S. Census Bureau, 2009). Changes in census reporting now allow us to more accurately count culturally diverse populations such as the number of gay and lesbian

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households. Using U.S. Census Data from 1990 and 2000, Rosenthal et al. (2003) estimated the number of gay people living in same-sex households at 1.2 million. However, these data do not reflect the total gay population because gay individuals often do not self report their sexual identity on census forms, some chose not to disclose their true living situation out of fear, and census data only counts households. This population estimate reflects those who reported living in a household with an unmarried partner. The National Health and Social Life Survey estimated the U.S. gay and lesbian population at 4 million or 2.8 percent of the population (Rubenstein, Sears, & Sockloskie, 2003).

It's no secret that our population is also aging. National projections indicate the number of people age 65 and over will increase by 30 million from 2010 to 2030 (U.S. Census Bureau, 2009). Fertility, life expectancy and net immigration are all causal factors in the shifting dynamics of the population (U.S. Census Bureau). Such a substantial shift in the geriatric population will require an expansion of services to meet their healthcare needs. The purpose of this article is to examine the historical roots of ethical service delivery and explore current trends and recommendations for service delivery with a specific focus on the GLBT population.

## **Human Rights and Ethical Service Delivery**

Providing ethical service delivery is the duty of all health care professionals. Typically professional associations, licensing boards, governmental and non-governmental agencies as

well as laws and historical precedent require adherence to a code of ethics. The language used in a code of ethics may strongly support a principle of non-discrimination. ASHA's Code of Ethics supports nondiscrimination (ASHA, 2003).

Attention to and respect for human rights is a relatively new phenomenon. Historically, rules and codes of conduct were established to prevent conflict. Established religion played a role by codifying rules and regulations for individual followers out of respect for one another, service to mankind, and obligation to their Creator. Nations and empires created rules in order to maintain peace and order. Flowers (1998) indicated that all societies, whether in oral or written tradition, have had systems of propriety and justice as well as ways of tending to the health and welfare of their members. Therefore, the roots for ethical treatment in service delivery are found in the historical evolution of human rights.

Rules designed to enhance social cohesiveness gave way to concern for individual rights. This developed in part due to the influence of major philosophers such as John Locke and because of questions about government control over individual rights such as freedom of religion. In the 1600s, according to Raynor (2009), the English Revolution and later the Glorious Revolution were fought over such issues and resulted in the creation of the English Bill of Rights. This document and our own Declaration of Independence and Constitution elevated individual rights and made governments more responsible to the people. But the rights contained in these documents followed social norms of the time, so African Americans and women did not share equal rights. Rights for these two groups were added later through amendments to the U.S. Constitution. The Equal Rights Amendment for women was never adopted. The struggle for equality among all people is a continuous process. Until all people are treated equally there will be a need for continued debate and consideration for the revision of laws and governmental and nongovernmental policies.

Concern for individuals from culturally diverse backgrounds emerged after World War I, but the real catalyst was the Holocaust and World War II when ethnic and minority cleansing

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occurred among Jews, homosexuals, Gypsies, and those with disabilities (Flowers, 1998). After the Holocaust and due in part to the efforts of Eleanor Roosevelt, the United Nations established The Universal Declaration of Human Rights. December 10, 2008, marked 60 years since its adoption (Todres, 2008).

Several notable parts of the Declaration are relevant to health care professionals as they examine their commitment to ethical service delivery. From its preamble, the Declaration affirms, "Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, ..." Later, it addresses social progress and improving standards of life by stating, "Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom....." Articles 1 and 2 provide powerful statements in support of human rights and equality. It's likely that most health care professionals have never considered the historical context from which the code of ethics that governs their practice evolved. As we consider those we serve on a daily basis, it's helpful to be mindful of the content contained within Articles 1 and 2 (United Nations, 1948).

Given the Declaration's intent that all humans treat one another in the "spirit of brotherhood" and Article 2's provision that the entitlement to "all the rights and freedoms" be inclusive of "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth and includes "or other status" this can be construed to include protection from discrimination based on sexual orientation and gender identification. Protections based on sexual orientation and gender identification were not considered during the original drafting of the Declaration because homosexuality and sexual identity were not discussed openly and had few advocates.

Progress at the United Nations on issues pertaining to human rights is tempered by a lack of consensus among conservative and progressive nations. Zeidan (2005) observes that human rights rooted in Western philosophy and based on "liberalism and individualism" are not accepted by many nations and may be resented as an attempt to change what is acceptable in

their culture. The difficulty inherent in attempts to expand human rights at the United Nations goes beyond the issue of sexual orientation. Issues such as women's rights and racism spark contentious debate.

Progress on GLBT issues is being made. In 2003, the United Nations Human Rights Commission supported an end to discrimination based on sexual orientation. The measure was tabled (Zeidan, 2005). More recently a nonbinding measure seeking to reject discrimination based on sexual orientation that decriminalizes homosexuality won the support of many nations but failed to pass. The United States refused to support the measure taking the familiar stance that decisions of this nature were best left to individual nations and states (MacFarquhar, 2008).

The advocacy work we do in support of equality and human rights is not complete. The protections we have now are the result of brave and courageous pioneers who stepped forward, often under ridicule, to support equality. The efforts we make today will benefit those who follow in our footsteps. Zeidan (2005) rightly states that vigilance must be maintained in the drive for equality least we allow extremist views to influence minority rights. He (p. 6) states, "...that

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Berlin's gays and lesbians would witness in the 1930's the most systematic assault in modern history could not have been predicted from the tolerant Bohemian atmosphere of the 1920's."

### ***Roadblocks to Equality***

Many people are working to make the world a better place. Examples abound with new initiatives designed to increase tolerance and a greater understanding of our own culture and that of those with which we are unfamiliar. As we strive to create a world where all people are created and treated equally, we often encounter roadblocks. Here is an example. In Atlanta's Southern Voice GLBT newspaper the headline from the December 26, 2008, edition read, "Rule change could allow doctors to reject gay patients" (Johnson, 2008, p. 6). On December 19, 2008, with an effective date of January 19, 2009, President Bush signed a new regulation allowing health care professionals to opt out of service delivery based on moral or conscience objections. According to Johnson's article, "...the rule allows the federal government to withhold funds from health care facilities if they do not permit workers to opt out of performing medical procedures they find objectionable based on religious or moral grounds." The cost to taxpayers for implementation of this new rule is \$44 million. While the intent of the new rule is aimed at the abortion debate and to support existing religious protections, its broad language could potentially be used to deny treatment to members of the GLBT community. Individuals already protected under federal legislation would not be affected. Sexual orientation is not protected under federal law (Johnson).

### ***United Nations Declaration***

The United Nations Universal Declaration of Human Rights combined with a general trend toward recognition of minority rights served as a catalyst to spur governmental and nongovernmental agencies, licensure boards, ASHA, and a host of oversight agencies to adopt nondiscrimination policies as a way to protect minorities and to prohibit discrimination.

Progress continues every day. This year, for example, ASHA's Multicultural Issues Board (MIB) was charged with developing a new position statement regarding culturally competent service delivery. This document, if approved, would establish a framework for culturally competent service delivery within our professions. Earlier in 2008, the MIB accepted a proposal and forwarded a recommendation to ASHA regarding the inclusion of gender identity as a protected class under the article on nondiscrimination in the ASHA's Code of Ethics.

In our daily professional lives, clinicians interact with health care professionals from a variety of fields. Many of these individuals belong to their own professional organizations. Each of these professional bodies abides by a code of ethics. A few of these professional bodies' codes of ethics are considered below. The language used to define each code varies considerably. Comparisons are reviewed below and a link to each code is included.

### ***Allied and Professional Association Code of Ethics***

The social work profession has a comprehensive and thorough Code of Ethics (<http://www.socialworkers.org/pubs/code/code.asp>). In the preamble, the profession includes as part of its mission, "...particular attention to the needs and empowerment of people who are

vulnerable, oppressed, and living in poverty.” Further, “Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice” (NASW, 2008). The ethical principles include attention to cultural and ethnic  
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diversity. The code also includes an ethical standard addressing cultural competence. It’s the only one of the eight code of ethics reviewed to include such a standard.

### **ASHA and AAA**

ASHA (<http://www.asha.org/docs/html/ET2003-00166.html>) and The American Academy of Audiology (AAA,

<http://www.audiology.org/resources/documentlibrary/Pages/codeofethics.aspx>) are inclusive and explicit in their ethical principles on nondiscrimination. ASHA’s Principle of Ethics I Rule C states, “Individuals shall not discriminate in the delivery of professional services or the conduct of research and scholarly activities on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation, or disability” (ASHA, 2003).

### **AOTA**

The American Occupational Therapy Association

(<http://www.aota.org/Practitioners/Ethics/Docs.aspx>) uses broader language. Principle 1 (A) says, “They shall recognize and appreciate the cultural components of economics, geography, race, ethnicity, religious and political factors, marital status, age, sexual orientation, gender identity, and disability of all recipients of their services” (AOTA, 2005). The words “shall not” and “will not” used in the AAA and ASHA Codes of Ethics are strong directives as compared to the AOTA’s “recognize and appreciate.” ASHA members should take pride in the fact that their professional organization’s Code of Ethics strongly supports nondiscrimination and uses strong language to do so.

### **AMA, ANA, and APTA**

Three high profile health care professions, doctors (<http://www.amaassn.org/ama/pub/category/2512.html>) nurses

(<http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/EthicsStandards/CodeofEthics/2110Provisions.aspx>) and physical therapists

([http://www.apta.org/AM/Template.cfm?Section=Core\\_Documents1&Template=/CM/HTMLDisplay.cfm&ContentID=25854](http://www.apta.org/AM/Template.cfm?Section=Core_Documents1&Template=/CM/HTMLDisplay.cfm&ContentID=25854)) use less precise language in their ethical principles regarding nondiscrimination. In fact the American Medical Association’s (AMA) Principle of Medical Ethics VI could be interpreted such that discrimination could be allowed. It states, “A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care” (AMA, 2001). The American Nurses Association (ANA) Provision 1 says, “The nurse, in all professional relationships, practices with compassion and respect, inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of problems” (ANA, 2001). The American Physical Therapy Association’s (APTA) Principle 1 simply states, “A physical therapist shall respect the rights and dignity of all individuals and shall provide compassionate care” (APTA, 1991).

Fortunately, these organizations typically have a Board of Ethics or, in the case of the American Medical Association, the Council on Ethical and Judicial Affairs. These boards and councils are given the responsibility to interpret and provide guidance on the principles contained within their code of ethics. Many have generated supporting documents (e.g., Issues in Ethics) that are used to interpret the ethical principles in their code. Prohibiting discrimination based on sexual orientation is part of AMA policy, for example, but it isn’t spelled out in its Code of Ethics.

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Quigley (2005) suggests public health research could also strengthen the language used in its ethical principles. In her presentation, at The American Public Health Association’s annual meeting in Philadelphia in December 2005, she identified the weaknesses found in the ethical principles guiding public health research as they relate to cultural competency. She stated that they “...fall short in dealing with ethical issues that pertain to multicultural communities and the complexities surrounding moral actions with culturally diverse values and knowledge traditions” (p. 28).

Clarifying and creating nondiscrimination policy hasn't always been easy. Schneider and Levin (1999) pointed out that it took years for the AMA's House of Delegates to support a resolution on a written nondiscrimination policy regarding sexual orientation. Since the measure passed in 1993, there has been a growing awareness and respect for inclusive policies designed to improve health care access and service delivery to the gay and lesbian community. For example, in 1998, the AMA'S Medical Student Association "...convened the first-ever meeting of a lesbian, gay, bisexual, and transgender caucus to serve as a resource for LGBT members and as a center of policy development" (Schneider & Levin, p. 1288).

The changing demographics of the communities we serve require health care professionals to become more knowledgeable about the cultural and linguistic diversity representative of their current and potential future client base. ASHA has strongly supported multiculturalism. The Bylaws, Code of Ethics and policy documents provide a firm foundation for inclusion and ethical service delivery.

### ***ASHA's Commitment to Diversity***

Through its Bylaws, Code of Ethics, the Office of Multicultural Affairs, the Multicultural Constituency Groups, scope of practice statements, preferred practice patterns, position statements, and practice guidelines, ASHA's commitment to cultural and linguistic diversity is infused within the framework of the Association. This year marks the 40th anniversary of the founding of ASHA's Office of Multicultural Affairs. The office assists association members with issues related to cultural and linguistic diversity. ASHA's Multicultural Issues Board serves to "Review, monitor, and recommend Association policies and actions on diverse populations as they pertain to its students, professionals, and consumers. Multicultural Constituency Groups include the following related professional organizations: Native American Caucus, National Black Association for Speech-Language and Hearing (NBASLH), Hispanic Caucus, Asian Indian Caucus, Asian Pacific Islander Caucus, and the L'GASP -GLBT Caucus.

ASHA's Code of Ethics is an inclusive document that attempts to protect those individuals deemed most likely to experience discrimination. Its language is stronger than that found in the Code of Ethics of other health care organizations. What happens when ASHA's Code of Ethics conflicts with state or federal employee protections such as the new "conscience objector" rule recently signed by President Bush? The answer to this particular situation isn't easy, but ASHA does provide some guidance. In this unlikely scenario, ASHA's Board of Ethics would likely be asked to review the situation. In an article in the February 4, 2003, *The ASHA Leader*, speech-language pathologist and attorney Melanie Frazek answers such a question. In her article "Ethics vs. Legal Jurisdiction," Frazek (2003) suggests that ASHA members are subject to the regulations of all governmental agencies (licensure boards) and nongovernmental agencies (ASHA) that oversee their practice. If an ASHA member is accused of discrimination not explicitly prohibited by state or federal regulations, the member could still be held accountable

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under the ASHA Code of Ethics. Frazek (p. 30) suggests that, "Where there may be a potential conflict in varying regulations, the best rule of thumb is to follow the higher standard."

### ***Overview of Gay Issues in Health Care***

GLBT populations encounter unique barriers and circumstances within the health care environment. A few examples are provided. In 2008, Ashleigh Haberman and Erica Schaub went to the South Pavillion Urgent Care facility, part of Spectrum Health Care in Grand Rapids, MI, for treatment of a lengthy cold. They weren't denied service, but they were given a lecture on gay marriage by the attending physician. They complained and filed a grievance with the Grand Rapids Community Relations Commission. Spectrum Health issued an apology (Beighley, 2008). GayHealth (2009) reported that California resident and lesbian Guadalupe Benitez was treated by physicians who gave her fertility drugs but refused to artificially inseminate her. They asked her to do it herself at home. She sued, and the California Supreme Court ruled in her favor based on California state law prohibiting discrimination against sexual orientation.

Unfortunately, these situations are not uncommon. GayHealth reported having received many complaints from the GLBT community about verbal harassment and denial of care from physicians and health care workers. Huebner, Rebchook, and Kegeles (2004) reported that, in the general population, 37% of young gay and bisexual men reported harassment, and 11%

reported discrimination. Since the health care community is a microcosm of society, it is likely that similar levels of harassment and discrimination are prevalent among health care professionals.

Members of the GLBT community usually try to find health care providers who are gay or gay friendly. This isn't always an option, however, especially in a rural community, a new city or an emergent need. Sympathetic, nonjudgmental care with regard to the health care needs of the GLBT community is desirable but often missing. GLBT individuals fear rejection through prejudice and may be less likely to go to the doctor. "A 2006 study of 5,500 gay men, lesbians, bisexual, transgender, and intersex (GLBTI) people in Australia found that nearly 70 percent of GLBTI people modify their daily activities because of fear of prejudice" (Better Health Channel, n.d.). This can be dangerous. GLBT individuals have higher rates of lung cancer, mental health disorders, obesity, and drug and alcohol abuse (Better Health Channel). These problems combined with the concerns and treatment needs of those with HIV and a greater risk for sexually transmitted diseases makes primary medical care valuable. The need for adequate care that is respectful of diversity is paramount.

Members of a culturally and linguistically diverse population within the GLBT community have a greater likelihood of experiencing even more discrimination. Bellinger, Mays, and Cochran (1992) concluded that, "For U.S. black gay and bisexual men, entry into the AIDS-related network in search of health care, education or resources, carries with it also significant risk of experiencing discrimination, both from the heterosexual black community, where being gay is highly stigmatized and from white gay men insensitive to the racial/ethnic and cultural issues." Fortunately, especially in larger metropolitan areas, multiple GLBT and GLBT friendly health care professionals, gay physician practices and community clinics with special outreach to the gay community exist.

The Gay and Lesbian Medical Association (GLMA) has a Web site with a referral service that can be accessed to locate physicians in specific geographical areas. Aetna Insurance, in a press release from October 20, 2008, has agreed to link databases with GLMA. This is the first insurance carrier to do so (Business Wire, 2008). In addition, the executive director of GLMA

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was selected by the Joint Commission to assist with the development of hospital standards for cultural competency. New standards are expected to include a provision addressing hospital visitation rights for domestic partners (GLMA, 2008).

New initiatives are beginning or being developed to address GLBT discriminatory practices that still exist within health care. In 2008, the Human Rights Campaign launched the Healthcare Quality Index which rates hospitals based on their policies related to GLBT issues (MSNBC.com, 2008). A new program supported by the Human Rights Foundation called Divided We Fail is "... committed to compelling our leaders to find common-sense solutions to the problems facing health care and financial security for America's seniors" (HRC, 2009). The new program, in partnership with several groups, including the American Association of Retired Persons, is designed to address the lack of Social Security survivor benefits for domestic partners, hospital health care decision-making, visitation, and an extension of the Family Medical Leave Act to include domestic partnership. Financial concerns over inheritance taxation on 401(k)s and an equity plan for health plan beneficiaries are additional concerns.

## **Conclusion**

Shifting demographics have created an emerging diverse population in the United States. Health care workers are faced with new challenges in service delivery as they encounter individuals from culturally linguistically diverse backgrounds. The Code of Ethics of ASHA prohibits discrimination. The Bylaws of the Association along with policy documents strongly support multiculturalism. The GLBT community in the United States often experiences discrimination in the health care system. Cultural competency standards are used to provide education to the health care community about how to deal with individuals from the GLBT community. Partnerships between health care and GLBT organizations have been created. Access and service delivery are improving for this population.

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## **Appendix**

### **ASHA resources**

1. ASHA's Office of Multicultural Affairs (OMA) <http://www.asha.org/about/Leadershipprojects/multicultural/> Contains specific links to educational materials on improving cultural competence, resources for research, and links for language assistance.

2. ASHA's Board of Ethics <http://www.asha.org/about/leadership-projects/committees/vpqsplpethics.htm>

3. Issues in Ethics issue on Cultural Competence can be found at

<http://www.asha.org/docs/html/ET2005-00174.html> This document provides guidance and direction to members in the provision of ethical service delivery to culturally and linguistically diverse populations.

4. ASHA's Code of Ethics and Bylaws <http://www.asha.org/about/Leadership-projects/>

5. ASHA's Multicultural Issues Board <http://www.asha.org/about/leadershipprojects/committees/vpapMib.htm>

6. The Knowledge and Skills Needed by Speech-Language Pathologists and Audiologists to Provide Culturally and Linguistically Appropriate Services <http://www.asha.org/docs/html/KS2004-00215.html>

7. Position Statements, Guidelines, Technical Reports, and Related Papers are on the Office of Multicultural Affairs Web page at <http://www.asha.org/about/leadershipprojects/multicultural/readings/position.htm>

8. Got it? Get it? Cultural competence (ASHA, 2009). <http://www.asha.org/about/leadershipprojects/multicultural/Gotit.htm> Contains information and links on developing cultural competence. Self-assessment is available through a link to several cultural competence checklists.

### **The ASHA Leader articles of interest**

1. How to create more sensitive environments for gay, lesbian, bisexual, and transgender clients (James Lee, 2002) <http://www.asha.org/about/publications/leaderonline/archives/2002/q2/020402f.htm>

2. Cultural competence in dysphagia (Luis F. Riquelme, 2004) <http://www.asha.org/about/publications/leaderonline/archives/2004/040413/f040413b3.htm>

3. Cultural competence in health care (Moxley & Vega-Barachowitz, C., 2004) <http://www.asha.org/about/publications/leaderonline/archives/2004/040413/f040413b1.htm>

4. Cultivating cultural competence in the workplace, classroom, and clinic (Tomoeda, K., & Bayles, K., 2002) <http://www.asha.org/about/publications/leader-online/archives/2002/q2/020402d.htm>

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### **Selected Web sites and resources**

1. Center for Medicare and Medicaid Services <http://www.cms.hhs.gov/>

2. Medical Learning Network

<http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA0621.pdf>

3. Think Cultural Health <http://www.thinkculturalhealth.org/>

4. U.S. Department of Health and Human Services Office of Minority Health <http://www.omhrc.gov/>

5. National Standards on Culturally and Linguistically Appropriate Services (CLAS) <http://www.omhrc.gov/templates/browse?lvl=2&lvlID=15>

6. The National Center for Cultural Competence  
<http://www11.georgetown.edu/research/gucchd/nccc/>
7. U.S. Department of Health and Human Services Health Resources and Services Administration  
<http://www.hrsa.gov/>
8. Diversity RX <http://www.diversityrx.org/>
9. Center for Effective Collaboration and Practice <http://cecp.air.org/>
10. Cultural Competence Online <http://www.culturalcompetence2.com/links.html>
11. U.S. Office of Minority Health <http://www.omhrc.gov/>
12. Human Rights Watch <http://www.hrw.org/press/index.html>
13. NASW National Association of Social Workers Code of Ethics  
<http://www.socialworkers.org/pubs/code/code.asp>
14. APTA American Physical Therapy Association Code of Ethics  
[http://www.apta.org/AM/Template.cfm?Section=Core\\_Documents1&Template=/CM/HTMLDisplay.cfm&ContentID=25854](http://www.apta.org/AM/Template.cfm?Section=Core_Documents1&Template=/CM/HTMLDisplay.cfm&ContentID=25854)
15. American Nurses Association Code of Ethics  
<http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/EthicsStandards/CodeofEthics/2110Provisions.aspx>
16. SOPHE Society for Public Health Education Code of Ethics  
<http://www.sophe.org/about/ethics.html>
17. The American Occupational Therapy Association Code of Ethics  
<http://www.aota.org/Practitioners/Ethics/Docs.aspx>
18. American Medical Association Principles of Medical Ethics <http://www.ama-assn.org/ama/pub/category/2512.html>
19. Public Health Leadership Society Code of Ethics <http://www.apha.org/NR/rdonlyres/1CED3CEA-287E-4185-9CBD-BD405FC60856/0/ethicsbrochure.pdf>
20. American Academy of Audiology Code of Ethics  
<http://www.audiology.org/resources/documentlibrary/Pages/codeofethics.aspx>
21. American Dietetic Association Code of Ethics [http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/advocacy\\_8218\\_ENU\\_HTML.htm](http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/advocacy_8218_ENU_HTML.htm)
22. American Medical Association Code of Ethics <http://www.ama-assn.org/ama/pub/category/2512.html>
23. Think Cultural Health U.S. Department of Health and Human Services Office of Minority Health  
<http://www.thinkculturalhealth.org/>
24. National Standards on Culturally and Linguistically Appropriate Services  
<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>
25. Quality Improvement Organization Support Center (UQIOSC) <http://www.qsource.org/uqiosc>